

RESPONSE PLAN OVERVIEW

RESPONSE PLAN OVERVIEW: TABLE OF CONTENTS

THE CHALLENGE OF COVID-19.....	1
RESPONSE PLAN MODULES.....	3
DEFINITIONS	4
GENERAL PRINCIPLES OF A PANDEMIC RESPONSE.....	6
A. THREE PHASES OF RESPONSE: PREPARATION, RESPONSE, AND RECOVERY	6
B. CONTAINMENT AND MITIGATION	6
C. COORDINATION	7
D. COMMUNICATION	7
E. QUALITY IMPROVEMENT (QI)	8
F. EDUCATION AND TRAINING	8

THE CHALLENGE OF COVID-19

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), a novel coronavirus, is responsible for the clinical presentation of coronavirus disease 2019 (COVID-19). This is a respiratory illness—first described in Wuhan, China, in December 2019—that spread rapidly and is currently a global pandemic. The COVID-19 pandemic arrived at the Federal Bureau of Prisons’ (BOP) institutions in mid-March 2020; today, every facility has identified confirmed cases.

A **PANDEMIC** refers to the international occurrence or spread of a particular disease, most commonly an infectious disease. More localized spread of disease is usually referred to as an **EPIDEMIC** or an **OUTBREAK**.

- Pandemics may occur for a variety of reasons, including **MUTATION** of existing pathogens (as is usually the case for the influenza virus) or development of **NEW PATHOGENS** like the severe acute respiratory syndrome coronavirus 2 (**SARS-CoV-2**), which is causing the current coronavirus disease 2019 (**COVID-19**) pandemic.
- An important characteristic of a pandemic caused by an infectious disease is the **ABILITY OF THE DISEASE TO BE TRANSMITTED** from one human to another. With Sars-CoV-2, human-to-human transmission first occurred in China in late 2019 and then spread globally in early 2020.
- Other important aspects that determine the disease’s impact are its mode of **TRANSMISSION**, **INFECTIVITY**, and **VIRULENCE**.
 - **TRANSMISSION:** SARS-CoV-2 is spread primarily when an infected person coughs, sneezes, or speaks, thereby dispersing respiratory droplets that land on the mucous membranes of another person’s nose, mouth, or eyes. The dispersal range for these droplets is about six feet. It may also be transmitted when a person touches a surface contaminated by infectious respiratory droplets and then touches their face, or when respiratory aerosols are generated during certain procedures.
 - **INFECTIVITY:** At first, it was thought that the virus was spread primarily by people who had developed symptoms of the disease—and that focusing efforts on these cases would be sufficient to contain the disease. It has since been determined that a significant number of people may be

transmitting the disease during asymptomatic, presymptomatic, or minimally symptomatic phases of the illness, which has contributed to the infectivity and communicability of the disease.

- **VIRULENCE AND SYMPTOMS:** Lastly, there is a wide range in **SEVERITY OF ILLNESS** (virulence), with current data indicating that the vast majority of cases are in the spectrum of asymptomatic to mild/moderate symptoms.
 - The **MOST COMMON SYMPTOMS** are cough and fever. Shortness of breath has been considered one of the three primary symptoms, but occurs less commonly than the other two.
 - Other **LESS COMMON SYMPTOMS** include body aches, headaches, sore throat, diarrhea, nausea, vomiting, abdominal pain, loss of smell or taste, and runny nose.
 - **Approximately 20 percent of cases will have severe or life-threatening illness and up to two to three percent of patients will die.** Some experts in the field estimate the mortality rate may be 10 times higher than that of seasonal influenza.
- **POST- COVID CONDITIONS:** Post-COVID conditions is an umbrella term for the wide range of physical and mental health consequences present four or more weeks after acute-COVID illness. A patient's immune response appears to dictate long-term consequences to SARS-CoV-2. This immune response is dependent on multiple variables including viral virulence, exposure intensity and duration to the virus, and the host's comorbid medical conditions. Cellular damage from SARS-CoV-2 may cause long-term health consequences, including multiple organ injury. Patients who recover from COVID-19 may not be contagious, but these patients may complain of new, recurrent, or persistent symptoms.
 - Individuals who suffered mild or moderate illness presenting with persistent post-COVID-19 symptoms are called **LONG-HAULERS**. The most common persistent symptoms are fatigue, dyspnea/cough, headache, and joint aches.
 - As patients begin to recover from COVID-19, some individuals who suffered severe COVID illness may develop complications such as blood clotting, myocardial injury, liver injury, renal injury requiring long-term dialysis, and neurological injuries such as strokes, confusion, and anxiety. An estimated 20–50% of COVID-19 patients will continue to have health challenges post-hospitalization.
 - Recovered patients with complaint of new, recurrent, or persistent symptoms after acute COVID-19 should be monitored for long-term sequelae.

In addition to being highly contagious and potentially fatal, COVID-19 presents a number of other challenges including knowledge gaps about the disease, rapidly changing clinical guidance vaccine hesitancy, difficulty preventing its spread in residential settings like correctional and detention facilities, and severe impacts on institutional and organizational operations created by staffing and supply shortages or large numbers of sick patients.

- **Knowledge about COVID-19 and public health guidance for responding to this pandemic is evolving quickly.** Practical tools, together with infection prevention and control plans for COVID-19, are being developed and edited frequently to correspond to current guidance from the Centers of Disease Control (CDC) and the World Health Organization (WHO).
- **COVID-19 presents unique challenges for management in the confined correctional environment.** Cases of COVID-19 have been documented in all 50 U.S. states. Because many individuals infected with COVID-19 do not display symptoms, the virus could be present in facilities before infections are

identified. Good hygiene practices, vigilant symptom screening, wearing of cloth face coverings, and social distancing are critical in preventing further transmission.

The COVID-19 pandemic is the most severe pandemic to affect this country in over 100 years, and must be approached with a sense of urgency. An effective response is possible, but requires rethinking of routine processes, procedures, policies, and priorities, in addition to the application of established infection prevention practices.

This document is designed to provide specific guidance on responding effectively to these challenges—and limiting the spread of COVID-19, its impact on people’s lives, and the BOP’s missional and operational effectiveness. Effective response to the challenge of COVID-19 requires that all disciplines in a correctional facility come together to develop, implement, and modify plans as information and conditions change.

Swift, decisive, yet evidenced-based planning is paramount.

RESPONSE PLAN MODULES

The **BOP COVID-19 Pandemic Response Plan** is divided into the following **MODULES**, each providing a detailed outline for correctional facilities. The modules will be updated as needed, based on guidance from key stakeholders including the CDC, WHO, and DOJ; recommendations are revised as new information becomes available.

➔ *It is important that the user check back periodically for updates to this plan.*

- **MODULE 1.** Infection Prevention and Control Measures
- **MODULE 2.** Personal Protective Equipment
- **MODULE 3.** Screening and Testing
- **MODULE 4.** Inmate Isolation and Quarantine
- **MODULE 5.** Surveillance
- **MODULE 6.** Inmate Movement
- **MODULE 7.** Non-COVID Routing Medical and Dental Services
- **MODULE 8.** Inmate Programming & Services
- **MODULE 9.** Inmate Visitation
- **MODULE 10.** Volunteer and Contract Staff Management
- **MODULE 11.** BOP Employee Management

DEFINITIONS

BOP INSTITUTION STAFF: BOP employees who work within the correctional setting.

BOP NON-INSTITUTION STAFF: BOP employees who work outside the correctional setting, i.e., Regional Office, Central Office, Grand Prairie, Staff Training Academy, Management and Specialty Training Center.

CLOSE CONTACT: In the context of COVID-19, an individual is considered a close contact if they have not been wearing appropriate PPE **and**:

- Have been within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) **OR**
- Had direct contact with infectious secretions of a COVID-19 case.

Considerations when assessing close contacts include the proximity to the infected person, duration of exposure, and the clinical symptoms of the person with COVID-19 (i.e., coughing likely increases exposure risk as does an exposure to severely ill persons).

COHORTING: The practice of grouping patients infected or colonized with or potentially exposed to the same infectious agent together to confine their care to one area and prevent contact with susceptible patients. In the BOP, this may refer to housing inmates of similar infection status together rather than in single cells.

CONTACT TRACING: Identifying people infected with COVID-19 (**CASES**) and the people with whom they came into contact (**CONTACTS**); and then working with them to interrupt disease spread. Contact tracing for COVID-19 typically involves:

- Interviewing people with COVID-19 (**CASE INVESTIGATION**) to identify everyone they had close contact with during the time they may have been infectious.
- Notifying contacts of their potential exposure.
- Referring contacts for testing and quarantine/isolation, as indicated
- Monitoring contacts for signs and symptoms of COVID-19

FULLY VACCINATED: Having completed a vaccination series: 2 weeks after their second dose in a 2-dose series (Pfizer or Moderna), or 2 weeks after a single-dose vaccine (Janssen) as authorized by the U.S. Food and Drug Administration of the United States. Proper documentation, including the name of the vaccine and dose administration dates from an official / reliable source, is required for a person to be considered fully vaccinated.

INCUBATION PERIOD: The stage of subclinical disease that extends from the time of exposure to the onset of disease symptoms.

MEDICAL ISOLATION: Confining individuals with suspected (displaying symptoms) or confirmed (based on a positive point of care (POC) or commercial laboratory test) COVID-19 infection, either to single rooms or by **COHORTING** them with other viral infection patients.

MINIMAL TOLERABLE RISK: The principle of choosing the option that presents the lowest possible risk when ideal conditions cannot be upheld.

NOT FULLY VACCINATED: No documentation of vaccination, partial vaccination (one out of two doses), or less than 14 days have passed following completion of the vaccine series as authorized by the U.S. Food and Drug Administration.

QUARANTINE: In the context of COVID-19, refers to separating (in an individual room or cohorting in a unit) asymptomatic not fully vaccinated persons to (1) observe them for symptoms and signs of the illness during the **INCUBATION PERIOD** and (2) keep them apart from other incarcerated individuals.

- The BOP utilizes **THREE CATEGORIES OF QUARANTINE** – exposure, intake, and release/transfer
- The need to quarantine during inmate movement is affected by vaccination status, type of inmate movement, the inmate's destination and point of origin, and operational level of the sending institution.

SYMPTOMATIC: People with confirmed COVID-19 have reported a wide range of symptoms that typically appear 2–14 days after exposure to the virus. People with confirmed or suspected COVID-19 infection presenting with any of the following symptoms are considered symptomatic:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

SOCIAL DISTANCING (a.k.a. PHYSICAL DISTANCING): Maintaining a distance of approximately six feet or more between each individual.

SURVEILLANCE: The ongoing systematic collection, analysis, and interpretation of **HEALTH-RELATED DATA**, closely integrated with the **TIMELY DISSEMINATION** of this data to those responsible for preventing and controlling disease and injury. Health data is defined and standardized by the Health Services Division and collected in a uniform and systematic manner. The authoritative and primary source of medical information is the electronic health record.

UP-TO-DATE VACCINATION STATUS: Proper documentation of having completed a vaccination series, and having received a booster according to current recommendations.

GENERAL PRINCIPLES OF A PANDEMIC RESPONSE

A. THREE PHASES OF RESPONSE: PREPARATION, RESPONSE, AND RECOVERY

The pandemic response is divided into three distinct, but overlapping, stages based on the time course of the pandemic: **PREPARATION**, **RESPONSE**, and **RECOVERY**. Individual institutions may be in different stages depending on whether they have had COVID-19 cases at their facility.

- **PREPARATION:** The importance for institutions to develop a response plan **PRIOR** to a local outbreak cannot be overstated. The plan should clearly define a systematic process for all of the elements outlined in the modules.
- **RESPONSE:** Upon identification of the first case, institution executive and medical staff should immediately:
 - Implement the local response plan.
 - Initiate and maintain communication with the regional medical director, health services administrator, and the QI/IP&C consultant.
- **RECOVERY:** This period will involve recovering from the effects of the pandemic emergency, evaluating the BOP response to it, and using this evaluation to prepare for subsequent waves of pandemic.

B. CONTAINMENT AND MITIGATION

Two major goals of a pandemic response are containment and mitigation:

- **CONTAINMENT:** To **LIMIT OR PREVENT SPREAD OF THE DISEASE**. For example, symptom screening, quarantine, and isolation are all containment efforts intended to limit the spread of disease.
- **MITIGATION:** To **LIMIT THE IMPACT OF THE DISEASE ON OPERATIONS** and to address operational challenges and disruptions created by the pandemic. Examples of such strategies include developing modified policies and procedures for routine operations, using alternative PPE strategies due to supply shortages, or setting up alternate care facilities to meet an increased demand for COVID-19-related health care.

CONTAINMENT STRATEGIES

There are a number of important containment strategies to be implemented.

- Environmental cleaning/disinfection/sanitation
- Health and hygiene practices:
 - Face covering (all inmates and staff in public places, with exceptions)
 - Covering the mouth and nose when coughing or sneezing
 - Hand hygiene – wash hands regularly with soap and water for at least 20 seconds or use hand sanitizer
 - Reporting illness early (staff and inmates) and staying home when sick (staff)
- Physical (social) distancing
- Screening for COVID-19 symptoms and signs (elevated temperature)

- Isolation, quarantine, PPE, and testing are essential aspects of limiting transmission and will be considered elsewhere in the document.

MITIGATION SCENARIOS AND STRATEGIES: CONVENTIONAL, CONTINGENCY, AND CRISIS

A framework for understanding mitigation strategies identifies three levels of operational disruption:

- **CONVENTIONAL** scenarios and strategies refer to minimal or no disruptions in normal operations.
- **CONTINGENCY** scenarios and strategies refer to mild to moderate disruption or impact on operations.
- **CRISIS** scenarios and strategies refer to severe disruption or impact on operations.

This framework recognizes that pandemics can make ordinary or well-established standards difficult or impossible to achieve and proposes reasonable alternative standards that provide an acceptable balance of risk and benefit, in light of the limitations created by the pandemic.

- Examples include the CDC's Strategies to Optimize the Supply of PPE and Equipment during Shortages, the American Dental Association's recommendation to cancel non-urgent dental care, and the decision of many health systems to postpone routine or non-urgent health care interventions.

Mitigation strategies also need to address potential shortages in staffing, supplies, and the ability to provide certain services. Every aspect of the organization needs to have plans to address limitations and disruptions in these areas, including alternative means of providing essential services.

C. COORDINATION

- It is critically important that correctional and health care leadership, and leadership from all divisions and departments meet regularly to review the current status of COVID-19, review updated guidance from the CDC, and flexibly respond to changes in current conditions.
- Regular meetings should be held, roles and responsibilities for various aspects of the local, regional, and central office response determined, and evidence-based plans developed and rapidly implemented. Consideration should be given to activating the **INCIDENT COMMAND SYSTEM** within the agency and each individual facility to coordinate response to the crisis.
- Responsibility should be assigned for tracking updates to national and local COVID-19 guidance.

Questions from institutions regarding any of the guidance in this Response Plan should be referred to your Regional Medical Director (RMD), Regional Health Care team, and Regional Director / Regional Emergency Operations Centers. The RMDs are aware of the most relevant and recommended approaches.

The medical management of COVID-19—including testing, housing, and treatment strategies—are clinical decisions and deference should be given to the RMD regarding these decisions within the clinical context of each situation and scenario that presents at the respective institution.

D. COMMUNICATION

- **The importance of regular communication with staff, incarcerated persons, and their families cannot be over-emphasized.** Specific methods of communication for all groups should be established. Staff should be assigned responsibility for crafting and disseminating regular updates.
 - ➔ *This CDC website offers printable educational posters at: <https://www.cdc.gov/coronavirus/2019-ncov/communication/factsheets.html>. At the site, type "COVID-19" into the search window.*

- Identify points of contact with local public health authorities, and initiate and maintain ongoing communication regarding changes to testing procedures, guidelines, and reporting.
 - As part of plan preparation, communicate with community hospitals to discuss referral mechanisms for transferring severely ill patients to the hospital.
- ➔ *Questions or concerns from staff should be directed to the following email address:*
COVID-19Questions@bop.gov

E. QUALITY IMPROVEMENT (QI)

Periodically throughout the outbreak and at the conclusion of it, review the implementation of your agency's or institution's COVID-19 Pandemic Response Plan to identify what has worked well (best practices), what has not, and deviations from established guidance (opportunities for improvement). Total numbers of cases and contacts treated/evaluated should also be reviewed. Engage the QI committee in evaluating the facility's pandemic response, and identify areas for improvement that should be reported to the leadership team.

F. EDUCATION AND TRAINING

STAFF EDUCATION AND TRAINING

Agency leadership must have clearly-defined mechanisms and well-developed strategies for communicating information and updates broadly and regularly to the field.

Throughout all BOP locations, post signage (available at the CDC site listed above under [COMMUNICATION](#)) communicating the following:

- Symptoms of COVID-19 and hand hygiene instructions.
 - Advice: Stay at home when sick; if COVID-19 symptoms develop while on duty, leave the facility as soon as possible and follow the CDC recommendations for ["What to Do If You are Sick"](#).
 - Elements of the facility's COVID-19 Response Plan for keeping employees safe, including social distancing.
- ➔ *To encourage social distancing and limit the chances of viral transmission, large staff meetings and recalls should be discouraged.*

INMATE EDUCATION AND TRAINING

Throughout the facility, post [SIGNAGE](#) (available at the CDC site listed above under [COMMUNICATION](#)) communicating the following:

- Hand hygiene instructions and good health habits such as covering your cough and sneezes.
- Report symptoms of fever and/or cough or shortness of breath (and if another incarcerated person is coughing) to staff.
- Ensure that signage is understandable for non-English speaking persons and those with low literacy.
- Co-pays for respiratory illness symptoms or fever may be waived.
- Sharing drugs and drug preparation equipment can spread COVID-19.
- Plans to support communication with family members including visitation alternatives, if in-person visits are temporarily halted.
- What the institution is doing to keep incarcerated persons safe, including social distancing.

- ➔ *Weekly updates should be provided to the inmates via TRULINCS. To encourage social distancing and limit the chances of viral transmission, town halls should be discouraged.*